	08-03-12 11:54 }			4 UCCEPTA-4001	P9005/004	0 F-224
DEPAR	TMENT OF HEALTH RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES	45	# Q130117	FORMA	APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	fiPLE CONSTRUCTION / . [(OMB NO. (X3) DATE SUI COMPLET	RVEY
		445162	B. WING_		07/40	10040
NAME OF P	ROVIDER OR SUPPLIER		-L	REST ADDRESS, CITY, STATE, ZIP CODE	0//16	/2012
ASBURY	PLACE AT JOHNSON	N CITY	1	105 WEST MYTRLE AVENUE JOHNSON CITY, TN 37604		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DÉFICIENCY)	LD 8E	(XS) COMPLETION DATE
SS=G	consult with the resi known, notify the resi cor an interested fam accident involving th injury and has the pr intervention; a signif physical, mental, or deterioration in healt status in either life th clinical complication significantly (i.e., a n existing form of treat consequences, or to treatment); or a deci the resident from the §483.12(a). The facility must also and, if known, the re or interested family r change in room or ro specified in §483.15 resident rights under regulations as specif this section. The facility must reco the address and pho legal representative of This REQUIREMENT by:	diately inform the resident; dent's physician; and if sident's legal representative ily member when there is an experience resident which results in obtential for requiring physician icant change in the resident's psychosocial status (i.e., a th, mental, or psychosocial preatening conditions or s); a need to alter treatment eed to discontinue an atment due to adverse commence a new form of sion to transfer or discharge efacility as specified in a promptly notify the resident sident's legal representative member when there is a commate assignment as (e)(2); or a change in Federal or State law or ited in paragraph (b)(1) of ord and periodically update the number of the resident's or interested family member.	F 157	The filing of this Plan of Correction does not constitute admission that the deficience alleged did, in fact, exist. The Plan of Correction is filed as evidence of the facility to convit the requirement of participation and continue the provide high quality resident provide high quality resident provide high quality resident provide high quality resident notified of the status of the healing pressure ulcer at treatment order obtained July 11, 2012. 2. All licensed mursing staff been re-educated by the or designee on the Physical Notification policy and produced the provident of Physical Notification. To be computed by 8/10/12. 3. The DON or designee we audit the Medical Recorresidents per week for 4 weeks, then 5 residents per second providents.	was the ad new l on If have DON ician proper cian pleted Ill ds of 5	3/10/12
	Based on medical re	cord review, review of facility and interview, the facility		month for 3 months for appropriate Physician		
]				EE .		
		R/SUPPLIER REPRESENTATIVE'S SIGNA	TURE	TITLE	(Xe) DATE
	Mark de Hu			Administrator	8/:	3/12
у авпсюпс у	statement ending with an	asterisk (*) denotes a deficiency which	i the Institutio	on may be excused from correcting providing	g it is determi:	ned that

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

ИВ-ИЗ-112 11:54 FHOM-

Event ID: CWKE11

Facility ID: TN9003

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T-472 P0006/0040 F-224 DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES <u>OMB NO. 0938-0391</u> STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X3) DATE SURVEY COMPLETED (X2) MULTIPLE CONSTRUCTION A. BUILDING

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		445162	B. Wil	NG_		07/	16/2012
	ROVIDER OR SUPPLIER PLACE AT JOHNSO	N CITY		11	EET ADDRESS, CITY, STATE, ZIP CODE 05 WEST MYTRLE AVENUE OHNSON CITY, TN 37604		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X6) COMPLETION DATE
	for one (#27) of fort facility's failure result treatment and harm. The findings include Resident #27 was a March 7, 2012, with Peripheral Vascular Diabetes, and Demonstrates of the Peripheral Vascular Pe	hysician of a pressure ulcer y residents reviewed. The Ited in a delay of physician to resident #27. ed: dmitted to the facility on diagnoses including Disease, Hypertension, entia. ew of the admission Minimum on 13, 2012, revealed the for developing pressure 3 pressure ulcer (right heel), acing device for the bed, and issistance with bed mobility. ew of the Wound/Skin Healing 17, 2012, revealed, IIIRight heel0.5 x 0.9 x imeters)wound bed brown w of the Wound/Skin Healing 1, 2012, revealed, "(right is than) 0.2 ulation tissuesloughbrown weekly Wound Report dated iled "(right) lateral heel is than) 0.2	F	157	Notification of pressure and proper documentation. 4. The results of the auditable reviewed at the Qual Assurance Committee (Administrator, Facilities Director maintenance at housekeeping, MDS, we care nurse, Pharmacy, Services, Medical Director Medical Direct	ion. s will lity DON, s nd ound Social ctor, s) ree (3)	

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T-472 P0007/0040 F-224

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 445162 07/16/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 105 WEST MYTRLE AVENUE ASBURY PLACE AT JOHNSON CITY JOHNSON CITY, TN 37604 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION Ð (X5) COMPLETION DATE PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 157 Continued From page 2 F 157 eschar to (right) heel...0.5 cm x 1 cm...no other skin breakdown noted... ' Medical record review of a skin assessment dated July 6, 2012, revealed, "...healing stage (2) Rt (right) heel Stage (2) coccvx-noted 7/4/12 Reddened area around coccyx...Pressure sores are to be measured weekly by skin assessment nurse..." Medical record review revealed the next wound assessment dated July 11, 2012, revealed, "... eschar on (right heel) (1cm x 0.5 cm) 2 stage (2) wounds on coccyx (...3 cm x 1.5 cm) (...1.5 cm x 1 cm) Excoriated around wound bilat (bilateral) buttocks...Pressure sores are to be measured weekly by the skin assessment nurse..." Medical record review of the care plan dated March 15, 2012, revealed "...Perform complete skin assessment and record...1 time weekly starting 03/15/2012..." Review of the policy Stage III Pressure Ulcer, revealed, "...Cleanse area with normal saline or wound cleanser ... obtain physician order for one of the following...Pack wound with hydrogel and apply calcium alginate and cove dressing QD (everyday)...Pack wound with saline moist loose gauze and cover dressing BID (twice a day)...If indicated, Enzymatic debridement...to Necrotic area and apply telfa or saline moist loose gauze and cover dressing QD..." Medical record review of the Treatment Records (dated March 7, 2012, through March 31, 2012,)

and April 1, 2012, through July 31, 2012, revealed a treatment for Betadine to Right Heel daily.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES <u>OMB NO. 0938-0391</u> STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY COMPLETED (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION DENTIFICATION NUMBER: A. BUILDING B. WING 445162 07/16/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 105 WEST MYTRLE AVENUE ASBURY PLACE AT JOHNSON CITY JOHNSON CITY, TN 37604 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE ID PREFIX (X6) COMPLETION DATE PRÉFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY F 157 Continued From page 3 F 157 Medical record review revealed no physician's order on admission or after for any treatment for the stage ill pressure ulcer to the right heel. Interview on July 11, 2012, at 10:40 a.m. with the DON, in the conference room, confirmed no physician's order had been obtained since the resident's admission on March 7, 2012, for treatment for the stage III pressure ulcer on the right heel. Observation and interview on July 11, 2012, at 5:30 p.m. with the resident's physician revealed two stage 2 pressure ulcers on the coccyx and a pressure ulcer on the right heel with eachar, as described by the physician. interview with the physician on July 11, 2012, at 5:30 p.m., in the resident's room, confirmed the physician was unable to recall being notified of the stage III pressure ulcer to the right heel. 483.13(a) RIGHT TO BE FREE FROM F 221 SS=D PHYSICAL RESTRAINTS F221 Right to be Free from Physical Restraints The resident has the right to be free from any physical restraints imposed for purposes of 1. Side rail assessments have discipline or convenience, and not required to been completed for Resident # treat the resident's medical symptoms. 27 and # 106. Side rails were

FORM CMS-2567(02-99) Prévious Versions Obsolete

reviewed.

This REQUIREMENT is not met as evidenced

Based on medical record review, review of the

facility failed to assess for the use of a restraint

for two (#106, #27) residents of forty residents

facility policy, observation, and interview, the

Event ID: GWK@11

Facility ID: TN8003

If continuation sheet Page 4 of 32

8/10/12

discontinued on July 23, 2012.

been completed for all other

residents. To be completed by

Side rail assessments have

8/10/12.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 445162 07/16/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 105 WEST MYTRLE AVENUE **ASBURY PLACE AT JOHNSON CITY** JOHNSON CITY, TN 37604 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X4) ID ID (XS) COMPLETION DATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) F 221 Continued From page 4 F 221 3. All nursing staff have been reeducated by the DON or The findings included: designee on the completion of side rail assessments and Resident #106 was admitted to the facility on May 14, 2012, with diagnoses including Mental proper use of side rails. To be Disorder, Osteoporosis, Vertebral Fracture, and completed by 8/10/12. Dementia. 4. The DON or designee will Medical record review of the Minimum Data Set audit the Medical Records of 5 dated May 20, 2012, revealed the resident required extensive assistance with one person residents per week for 4 physical assist for bed mobility and transfers. weeks, then 5 residents per month for 3 months for Review of the facility policy, Restraints-Physical, revealed "...A physical restraint is defined as any appropriate documentation of article, device, or garment that is used primarily to side rail assessments. modify resident behavior by interfering with free movement...a physician's order is necessary for The results of the audits will the use of a physical restraint... The need for be reviewed at the Quality restraints will be reevaluated at least quarterly to determine if continued restraint use is necessary Assurance Committee (DON, to treat the resident's medical symptoms..." Administrator, Facilities Director maintenance and Observation on July 12, 2012, at 7:40 a.m., with housekeeping, MDS, wound Licensed Practical Nurse (LPN) #2, revealed the care nurse, Pharmacy, Social resident lying in a low bed with 1/4 siderails up located in the center of the bed to keep the Services, Medical Director, resident from exiting the bed. ADON, Dining Services) meeting monthly for three (3) Observation on July 16, 2012, at 1:30 p.m., with months and recommendations the Director of Nursing (DON) revealed the made as appropriate. resident lying in a low bed with 1/4 siderails in the mid bed position. Medical record review revealed no restraint assessment for the use of the siderails. Interview on July 16, 2012, at 12:55 p.m. with the

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED OMB NO. 0938-0391

STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
<u> </u>	<u> </u>	445162	B. WING		07/16/2012	
	PROVIDER OR SUPPLIER Y PLACE AT JOHNSO	N CITY		REET ADDRESS, CITY, STATE, ZIP CODE 105 WEST MYTRLE AVENUE JOHNSON CITY, TN 37604	41,10,2012	•
(X4) ID PREFIX TAG	EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREI (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD RE COMPLEX	ion
F 221	Continued From par DON, in the confere assessment had be the siderails as a re-	ence room, confirmed no en completed for the use of	F 221			
	March 7, 2012, with	Disease, Hypertension.				
	dated June 11, 2012 required extensive a physical assist for be	ew of the Minimum Data Set 2, revealed the resident issistance with two person and mobility and total to person physical assist for				
	revealed the residen	11, 2012, at 7:45 a.m. t lying in a low bed with 1/4 in the center of the bed to im exiting the bed.			-	
	Medical record review assessment for the u	w revealed no restraint . use of the siderails.				
	Assistant Director of room, confirmed no a completed for the us restraint.					
F 281 SS=D	483.20(k)(3)(i) SERV PROFESSIONAL ST	ICES PROVIDED MEET ANDARDS	F 281			
		d or arranged by the facility nal standards of quality.		F281 Services provided 1 professional standards	neet	
	This REQUIREMENT	is not met as evidenced				

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/GLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 445162 07/16/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 105 WEST MYTRLE AVENUE ASBURY PLACE AT JOHNSON CITY JOHNSON CITY, TN 37604 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE IĐ (X5) COMPLETION DATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG YAG DEFICIENCY F 281 Continued From page 6 F 281 1. Medication Administration Record for Resident #39 has Based on observation, medication record review, been verified for accuracy. and interview, the facility falled to follow The MD was notified of the physician's orders for medication administration for one (#39) of forty sampled residents. medication omission on July 11, 2012. The findings included: 2. All Medication Resident #39 was admitted to the facility on February 22, 2012, with diagnoses including Administration Records for -Congestive Heart Failure, Edema, and Coronary each resident have been Artery Disease. verified for accuracy against Physician Orders. To be Medical record review revealed an initial 7/31/12 completed by 7/31/12. psychiatric consult was obtained on May 11. 2012, for depression and medication management. Further review revealed the The Medication resident had been having increasingly paranoid Administration policy has thoughts. Further review revealed the resident been reviewed. The DON or was "accusing staff of morbid acts such as killing designee has re-educated all the resident and taking out the resident's licensed nursing staff on the arteries." Medication Administration Medical record review revealed the resident was policy and proper admitted to the hospital on May 18, 2012, and verification of the returned to the facility on May 21, 2012. Medical Medication Administration record review revealed a physician's order dated May 31, 2012, for Geodon (antipsychotic Record against Physician medication) 20 mg.(milligrams) to be given daily orders. To be completed by at 5:00 p.m. 8/10/12. Medical record review of the physician's signed 4. The DON or designee will recapituation (recap) orders for June 2012, conduct random audits of the revealed order for Geodon 20 mg. to be given at 5:00 p.m., pm (as necessary). Review of the Medication Administration medication administration record (MAR) for June Records for accuracy with 2012, revealed the resident only received the Physician orders. Audits medication on June 6, 11, 13, & 14, 2012, (four

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES <u>OMB NO. 0938-0391</u> STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING 8. WING 445162 07/16/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ASBURY PLACE AT JOHNSON CITY 105 WEST MYTRLE AVENUE JOHNSON CITY, TN 37604 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION D (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION DATE PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 281 will be done on 10 residents Continued From page 7 F 281 per week for 4 weeks, then out of thirty days) 10 residents per month for 3 Review of the Psychiatric Consultation Follow Up months. dated June 25, 2012, revealed the resident continued to have delusions and paranoia and the The results of the audits will recommendation was to continue Geodon 20 mg. daily at 5:00 p.m. be reviewed at the Quality Assurance Committee Medical record review of the MAR for July 2012, (DON, Administrator, revealed no documentation Geodon 20 mg. was Facilities Director given on July 3 or 4, 2012. maintenance and Interview with the Director of Nursing (DON) in housekeeping, MDS. the DON's office on July 11, 2012, at 2:45 p.m., Pharmacy, Social Services, confirmed the physician order sheet for June Medical Director, ADON, 2012, had been incorrectly transcribed and the Dining Services) meeting resident was to have received Geodon 20 mg. monthly for three (3) months daily (not prn). Further interview confirmed the resident had not received Geodon 20 mg. as and recommendations made ordered by the physician in June or July 2012. as appropriate. F 282 483.20(k)(3)(ii) SERVICES BY QUALIFIED F 282 SS=D PERSONS/PER CARE PLAN The services provided or arranged by the facility F282 Services by qualified must be provided by qualified persons in persons/per care plan accordance with each resident's written plan of care. 1. Poley catheter was changed on July 11, 2012 for This REQUIREMENT is not met as evidenced Resident #39. by: Based on medical record review and interview. 2. All other residents with the facility failed to follow a care plan for foley catheters were assessed indwelling catheter changes for one (#39) of forty to ensure proper foley care. residents reviewed. To be completed by 7/30/12.

The findings included:

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED

NAME OF PROVIDER OR SUPPLIER ASBURY PLACE AT JOHNSON CITY (A4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FILL REGULATORY OR LISC IDENTIFYING INFORMATION) F 282 Continued From page 8 Resident #39 was readmitted to the facility on May 21, 2012, with diagnosis including urinary retention. Review of the resident's Care Plan dated May 24, 2012, revealed intervention of "changecatheter and drainage bag every thirty days and pm (as necessary). Medical record review of hospital documentation revealed the resident's catheter was changed while in the hospital on May 21, 2012, with orders to change monthly. Medicat record review revealed no documentation of a catheter change since readmission (fifty-one days). Interview with the Director of Nursing (DON) in the DON's office on July 11, 2012, at 2:45 p.m., confirmed the resident's urinary catheter had not been changed since readmission on May 21, 2012. F 309 HIGHEST WELL BEING STREET ADDRESS, CITY, STATE, ZIP CODE 195 WEST MYTHE, AVENUE CORRECTION TO STREAM CORRECTION TO THE APPROPRIATE DEPOCH TO THE APPROPRIATE DEPOCH TO THE APPROPRIATE CORRECTION TO THE APPROPRIATE DEPOCH TO THE APPROPRIATE DEPOCH TO THE APPROPRIATE CORRECTION TO THE APPROPRIATE DEPOCH TO THE APPROPRIATE CORRECTION TO THE APPROPRIATE OF THE APPROPRIATE CORRECTION TO THE APPROPRIATE OF THE APPROPRIATE CORRECTION TO THE APPROPRIATE OF THE APPROPRIATE OF THE APPROPRIATE CORRECTION TO STREET ADDRESS, CITY, STATE, ZIP CODE CORRECTION TO STREET ADDRESS, CITY, STATE, ZIP CODE CORRECTION TO THE APPROPRIATE OF STATE APPROPRIATE CORRECTION TO STORM TO THE APPROPRIATE OF THE APPROPRIATE CORRECTION TO STREET ADDRESS, CITY, STATE, ZIP CODE CORRECTION TO STREET ADDRESS, CITY, STATE, ZIP CODE CORRECTION TO STREET ADDRESS, CITY, STATE, ZIP CODE CORRECTION TO STREET ADDRESS, CITY, STATE, ZIP COCRETION TO STREET ADDRESS, CITY, STATE, ZIP CORRECTION TO STREET	OTATEMEN		T STATE OF THE OF TAKEO				OWR NO	<u>. 0938-0391</u>	
ASBURY PLACE AT JOHNSON CITY (74) ID PREFIX TAG (74) ID PREFIX TAG (74) ID PREFIX TAG (75) ID PREFIX TAG (76) ID PROVIDE CARESTORNATION) (76) ID PROVIDE CARESTORNATION (76) ID PROVID	AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE S	(X3) DATE SURVEY	
ASBURY PLACE AT JOHNSON CITY (M) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION) F 282 Continued From page 8 Resident #39 was readmitted to the facility on May 21, 2012, with diagnosis including urinary retention. Review of the resident's Care Plan dated May 24, 2012, revealed intervention of "changecatheter and drainage bag every thirty days and prn (as necessary). Medical record review of hospital documentation revealed the resident's catheter was changed while in the hospital on May 21, 2012, with orders to change monthly. Medical record review revealed no documentation of a catheter change since readmission (fifty-one days). Interview with the Director of Nursing (DON) in the DON's office on July 11, 2012, at 2:45 p.m., confirmed the resident's uninary catheter had not been changed since readmission on May 21, 2012. F 309 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in			445162	B. WIN	NG	· · · · · · · · · · · · · · · · · · ·	07/1	16/2012	
SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG SUMMARY STATEMENT OF DEFICIENCY MIST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 282 Continued From page 8 Resident #39 was readmitted to the facility on May 21, 2012, with diagnosis including urinary retention. Review of the resident's Care Plan dated May 24, 2012, revealed intervention of "changecatheter and dralnage bag every thirty days and prn (as necessary). Medical record review of hospital documentation revealed the resident's catheter was changed while in the hospital on May 21, 2012, with orders to change monthly. Medical record review revealed no documentation of a catheter change since readmission (fifty-one days). Interview with the Director of Nursing (DON) in the DON's office on July 11, 2012, at 2:45 p.m., confirmed the resident's urinary catheter had not been changed since readmission on May 21, 2012. F 309 HIGHEST WELL BEING SUMMARY STATEMENT OF DEFICIENCY MIST TAG FROVIDERS PLAN OF CORRECTION (EACH CONNECTIVE ACTORS THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MIST ACTORS THE APPROPRIATE DEFICIENCY) F 282 3. The policy for Indwelling Foley Catheters was reviewed and revised. The DON or designee has re-educated the licensed nursing staff on the Indwelling Foley Catheter policy and proper foley care, To be completed by 8/10/12. 4. The DON or designee will conduct random audits of residents with indwelling foley catheters for proper foley care and adherence to current policy. Audits will be completed on 5 residents per week for 4 weeks, then 10 residents per month for 3 months.			N CITY		10	05 WEST MYTRLE AVENUE		16/2012	
Resident #39 was readmitted to the facility on May 21, 2012, with diagnosis including urinary retention. Review of the resident's Care Plan dated May 24, 2012, revealed intervention of "changecatheter and drainage bag every thirty days and prn (as necessary). Medical record review of hospital documentation revealed the resident's catheter was changed while in the hospital on May 21, 2012, with orders to change monthly. Medical record review revealed no documentation of a catheter change since readmission (fifty-one days). Interview with the Director of Nursing (DON) in the DON's office on July 11, 2012, at 2:45 p.m., confirmed the resident's urinary catheter had not been changed since readmission on May 21, 2012. F 309 SS=D HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FILL	PREFI	ıx	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP	OULD BE	(X5) COMPLETION DATE	
accordance with the comprehensive assessment and plan of care. 1. Medication Administration Record for Resident # 17 has been verified for accuracy. The MD was notified of the medication omission on July physician's orders for antipsychotic medication for	F 309	Resident #39 was r May 21, 2012, with retention. Review of the resid 2012, revealed interest and drainage bag e necessary). Medical record review revealed the resident while in the hospital to change monthly, revealed no docume since readmission (Interview with the Don's office on confirmed the reside been changed since 2012. 483.25 PROVIDE CHIGHEST WELL BE Each resident must provide the necessary or maintain the high mental, and psychosaccordance with the and plan of care. This REQUIREMEN by: Based on medical reand interview, the far	eadmitted to the facility on diagnosis including urinary ent's Care Plan dated May 24, rvention of "changecatheter very thirty days and prn (as ew of hospital documentation nt's catheter was changed on May 21, 2012, with orders Medical record review entation of a catheter change fifty-one days). irector of Nursing (DON) in July 11, 2012, at 2:45 p.m., ent's urinary catheter had not a readmission on May 21, ARE/SERVICES FOR EING Traceive and the facility must be tracticable physical, social well-being, in comprehensive assessment. T is not met as evidenced ecord review, observation, cility falled to follow			Foley Catheters was reviewed and revised DON or designee has educated the licensed nursing staff on the Indwelling Foley Capolicy and proper foley and proper foley and proper foley campleted by 4. The DON or designed conduct random audit residents with indwer foley catheters for proper foley care and adhered current policy. Audit be completed on 5 resper week for 4 weeks 10 residents per monomonths. F309 Provide care/service highest well being 1. Medication Administrated Record for Resident is been verified for according to the MD was notified medication omission.	theter ley care. 8/10/12. e will its of lling oper ence to ts will sidents s, then th for 3		

08-03-12 11:56 FRUM-

T-472 P0014/0040 F-224

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 445162 07/16/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 105 WEST MYTRLE AVENUE ASBURY PLACE AT JOHNSON CITY JOHNSON CITY, TN 37604 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE 1D (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG TAG DATE **DEFICIENCY**) F 309 Continued From page 9 F 309 2. All Medication one (#17) of forty residents reviewed. Administration Records for The findings included: each resident have been verified for accuracy against Resident #17 was admitted to the facility on July Physician Orders. To be 13, 2011, with diagnoses including Chronic 7/31/12 completed by 7/31/12. Airway Obstruction, Diabetes, Dementia with Depression, and Esophageal Reflux. 3. The Medication Medical record review of the Minimum Data Set Administration policy has dated June 21, 2012, revealed the resident had been reviewed. The DON or severe cognitive impairment and required designee has re-educated all assistance with all activities of daily living. licensed nursing staff on the Medical record review revealed the resident was Medication Administration placed on Risperidone (antipsychotic) 0.5 mg. policy and proper (milligrams) twice daily on July 13, 2011. Medical verification of the record review revealed a physician's order dated Medication Administration June 26, 2012, to decrease Risperidone to 0.25 Record against Physician mg. every morning and 0.25 mg, at bedtime. orders. To be completed by Review of the Medication Administration Record 8/10/12. (MAR) for June, 2012 revealed no documentation the resident received Risperdal at bedtime on 4. The DON or designee will June 26, 27, 28, 29, an 30, 2012 (5 days) Further conduct random audits of the review revealed no documentation the resident received Risperdal in the morning June 27, 28, Medication Administration 29, and 30, 2012 (4 days), Records for accuracy with Physician orders, Audits Review of the physician's recapituation orders for will be done on 10 residents July 2012, revealed an order for Risperdal 0.25 per week for 4 weeks, then mg. every morning and 0.5 mg. at bedtime. 10 residents per month for 3

Interview with the Director of Nursing (DON) in

the hallway on July 12, 2012, at 9:45 a.m., confirmed the medication order had been transcribed incorrectly on the physician's recap orders and the resident was to receive Risperdal months.

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T-472 P0015/0040 F-224

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES <u>OMB NO. 0938-0391</u> (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION COMPLETED A. BUILDING B. WING 445162 07/16/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ŻIP CODE ASBURY PLACE AT JOHNSON CITY 105 WEST MYTRLE AVENUE JOHNSON CITY, TN 37604 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE ĬĎ (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION DAYE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 309 Continued From page 10 F 309 The results of the audits will 0.25 mg, at bedtime. be reviewed at the Quality Assurance Committee Medical record review of the MAR for July, 2012, (DON, Administrator, revealed no documentation Risperdal 0.25 mg. was given at bedtime on July 1, 2, 3, 4, 5, 6, 7, 8, Facilities Director 9, 10, or 11, 2012 (11 days). maintenance and housekeeping, MDS. Observation on July 12, 2012, at 9:45 a.m., Pharmacy, Social Services, revealed the resident lying in bed with eyes closed. Medical Director, ADON, Dining Services) meeting Interview with the DON in the hallway on July 12, monthly for three (3) months 2012, at 9:45 a.m., confirmed the resident did not and recommendations made receive the bedtime dosage of Risperdal from June 26, through July 11, 2012, and no Risperdal as appropriate. 0.25 mg. morning dose was administered on June 27 - 30, 2012. 483.25(c) TREATMENT/SVCS TO F 314 F 314 PREVENT/HEAL PRESSURE SORES F314 Treatment/Sycs to SS≃G prevent/heal pressure sores Based on the comprehensive assessment of a resident, the facility must ensure that a resident 1. Skin Assessment was who enters the facility without pressure sores completed for Resident #27 does not develop pressure sores unless the individual's clinical condition demonstrates that on July 11, 2012. Wound they were unavoidable; and a resident having Assessment was completed pressure sores receives necessary treatment and for Resident #27. services to promote healing, prevent infection and Resident's Physician and prevent new sores from developing. Dietician were notified of pressure ulcer on July 11, This REQUIREMENT is not met as evidenced 2012. Based on medical record review, review of facility 2. Skin assessments were policy, review of the Dietician Contract. 7/เร/เจ completed on all other observation, and interview, the facility failed to

complete skin assessments, implement dietary

recommendations, obtain physician orders for

residents by 7/15/12.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

T-472 P0016/0040 F-224

FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES <u>OMB NO. 0938-0391</u> STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 445162 07/16/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ASBURY PLACE AT JOHNSON CITY 105 WEST MYTRLE AVENUE JOHNSON CITY, TN 37604 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) Continued From page 11 F 314 Skin Assessment and Wound wound treatments, ensure the Registered Dietician assessed the resident, and ensure Care policies were reviewed measures were in place to reduce pressure for and revised. The DON or resident #27. The facility also failed to ensure designee has re-educated all skin assessments were completed for resident licensed nursing staff on the #107. The facility's fallure resulted in delayed Skin Assessment and Wound treatments and harm to resident #27. Care policies and The findings included: procedures. To be completed 8/10/12. Resident #27 was admitted to the facility on 8/10/12 March 7, 2012, with diagnoses including 4. The DON or designee will Peripheral Vascular Disease, Hypertension. conduct random audits of the Diabetes, and Dementia. Skin Assessments and Medical record review of the admission Minimum Wound Care assessments for Data Set dated March 13, 2012, revealed the completion and accuracy. resident was at risk for developing pressure Audits will be done on 5 ulcers, had a stage 3 pressure ulcer (right heel). had a pressure reducing device for the bed, and residents per week for 4 required extensive assistance with bed mobility. weeks, then 5 residents per month for 3 months. Medical record review of the Wound/Skin Healing Record dated March 7, 2012, revealed, The results of the audits will "...pre-admit...stage III (pressure ulcer)...Right be reviewed at the Quality heel...0.5 x 0.9 x (less than) 0.2 (centimeters) ...wound bed brown (eschar)...' Assurance Committee (DON, Administrator, Medical record review of the Wound/Skin Healing Facilities Director Record dated April 3, 2012, revealed, "...(right maintenance and heel) 0.4 x 0.7 x (less than) 0.2 housekeeping, MDS, (centimeters)...granulation tissue...slough...brown eschar..." Pharmacy, Social Services, Medical Director, ADON, Review of the next Weekly Wound Report dated Dining Services) meeting April 17, 2012 (two week time period from the last

assessment) revealed "...(right) lateral heel stage $3.0.4 \times 0.7$ (less than) 0.2 (centimeters)...loose

monthly for three (3) months

08-03-12 11:56 FROM-T-472 P0017/0040 F-224 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING COMPLETED B. WING. 445162 07/16/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 105 WEST MYTRLE AVENUE ASBURY PLACE AT JOHNSON CITY JOHNSON CITY, TN 37604 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X4) ID ID (X5) COMPLETION DATE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 314 Continued From page 12 F 314 and recommendations made eschar..." as appropriate. Medical record review of a skin assessment dated June 12, 2012, revealed, "...small area of eschar to (right) heel...0.5 cm x 1 cm...no other skin breakdown noted... ' Medical record review of a skin assessment dated July 6, 2012, revealed, "...healing stage (2) (pressure ulcer) Rt (right) heel Stage (2) (pressure ulcer) coccyx-noted 7/4/12 Reddened area around coccyx...Pressure sores are to be measured weekly by skin assessment nurse..." Medical record review revealed the wound assessment completed on July 6, 2012 for the right heel pressure ulcer did not describe the size

Medical record review revealed the next wound assessment dated July 11, 2012, revealed, "... eschar on (right heel) (1cm x 0.5 cm) 2 stage (2) wounds on coccyx (...3 cm x 1.5 cm) (...1.5 cm x 1 cm) Excoriated around wound bilat (bilateral) buttocks...Pressure sores are to be measured weekly by the skin assessment nurse..."

or color of the wound.

Medical record review of the care plan dated March 15, 2012, revealed "...Perform complete skin assessment and record...1 time weekly starting 03/15/2012..."

Interview on July 11, 2012, at 2:15 p.m., with the Director of Nursing, in the conference room, confirmed the pressure ulcer on the coccyx identified on July 4, 2012 was found as a stage II sore. This resident was assessed on admission as hi-risk for pressure sores and required extensive assistance with bed mobility.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		FLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		445162	B. WI	NG_		07/	16/2012
	ROVIDER OR SUPPLIER PLACE AT JOHNSO	N CITY	•	1	REET ADDRESS, CITY, STATE, ZIP CODE 105 WEST MYTRLE AVENUE JOHNSON CITY, TN 37604		
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F 314	Continued From pa	6, 2012, at 1;30 p.m., with the	F:	314			
	wound assessment size and color had it pressure ulcer on the	in the hall, confirmed no with a full description of the been completed for the seright heel the week of April une 12, 2012 until July 11,					
	April 19, 2012, reve 3/7/12stage (3) (ri (albumin) 2.5 (refere	ight) lateral heel, labs alb ence range 3.2-4.6) on id Prosource liquid 1 oz					
	form dated May 17, Registered Dieticiar decub (decubitus) (i heelRecommend juice or other liquid	ew of a High Risk Follow-Up 2012, signed by the a, revealed "unstageable right) lateral 1 oz liquid protein in 6-8 oz bid (twice a day), Megace 400mg (milligrams) bid"					
-	Medical record revie dated May 18, 2012 protein bid and Meg	ew of a physician's order , revealed "1 oz liquid ace 400 mg bid"			· ·		
		ew of the Medication and revealed Prosource to aid in healing) was started					
	DON, in the confere (from April 19, 2012	, 2012, at 2:15 p.m, with the nce room, confirmed a delay until May 21, 2012, thirty-one the dietary recommendation			•		

00 00 TE TT'OL LEGGE T-472 P0019/0040 F-224 DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 445162 07/16/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ASBURY PLACE AT JOHNSON CITY 108 WEST MYTRLE AVENUE JOHNSON CITY, TN 37604 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PROVIDER'S PLAN OF CORRECTION PRÉFIX (X5) COMPLETION DATE PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) Continued From page 14 F 314 Review of the facility policy Stage III Pressure Ulcer, revealed, "... Cleanse area with normal saline or wound cleanser ...obtain physician order for one of the following...Pack wound with hydrogel and apply calcium alginate and cove dressing QD (everyday)...Pack wound with saline moist loose gauze and cover dressing BID (twice a day)...If indicated, Enzymatic debridement...to Necrotic area and apply telfa or saline moist loose gauze and cover dressing QD..." Medical record review of the Treatment Records dated March 7, 2012, through March 31, 2012. and April 1, 2012, through July 31, 2012, revealed a treatment of Betadine to Right Heel daily. Medical record review revealed no physician's order for the Betadine treatment or any physician ordered treatment since the resident's admission on March 7, 2012 for the stage III pressure ulcer to the right heel. Interview on July 11, 2012, at 10:40 a.m. with the DON, in the conference room, confirmed no

right heel.

physician's order had been obtained since the resident's admission on March 7, 2012, for treatment for the stage III pressure ulcer on the

Observation and interview on July 11, 2012, at 5:30 p.m. with the resident's physician revealed two stage 2 pressure ulcers on the coccyx and a pressure ulcer on the right heel with eschar, as described by the physician. Interview with the physician, at this time confirmed the physician was unable to recall being notified of the stage III pressure ulcer to the resident's right heel

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T-472 P0020/0040 F-224

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 445162 07/16/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ASBURY PLACE AT JOHNSON CITY 108 WEST MYTRLE AVENUE JOHNSON CITY, TN 37604 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG YAG DEFICIENCY) F 314 Continued From page 15 F 314 Medical record review of the care plan reviewed on May 31, 2012, revealed "... Use pillows, pads, or wedges to reduce pressure on heels and pressure points..." Observation and interview on July 12, 2012, at 8:30 a.m. with Certified Nursing Assistant (CNA) #1 revealed the resident lying on the bed with the heels touching the mattress. Review of the Dietitian Contract revealed, "...All patients with pressure ulcers (stage 2 or more) will be assessed monthly by the registered dietician..." Interview on July 16, 2012, at 10:45 a.m. in the conference room, with the Clinical Nutrition Director, confirmed the resident was not assessed by the Registered Dietician until April 19, 2012, a delay in assessment of forty-three days from the resident's admittance on March 7. 2012, with a stage 3 pressure ulcer. Resident #107 was admitted to the facility on May 25, 2012, with diagnoses including Hypertension, Systemic Lupus Erythematosus. Urinary Retention, Depressive Disorder, Chronic Back Pain, and Raynaud's Syndrome. Medical record review revealed the resident was discharged to the hospital on June 29, 2012. Medical record review of the admission Minimum Data Set dated June 2, 2012, revealed the resident scored fourteen on the Brief Interview for Mental Status (BIMS) indicating the resident was independent with daily decision making, required

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICARD SERVICES

T-472 P0021/0040 F-224

FORM APPROVED

STATEMEN	T OF DEFICIENCIES	1	-,-			OMB N	<u>0. 093</u> 8-0391
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		IPLE CONSTRUCTION	(X3) DATE COMP	SURVEY
		445162	B. WI	NG_	<u> </u>	07/	16/2012
	PROVIDER OR SUPPLIER PLACE AT JOHNSO	<u> </u>		1	REET ADDRESS, CITY, STATE, ZIP CODE 105 WEST MYTRLE AVENUE JOHNSON CITY, TN 37604		
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	extensive assistance and walking, had a risk for development pressure reducing dand chair. Medical record reviet Assessment Scale of a score of seventee below requires a we assessment/documerecord" Medical record reviet dated May 25, 2012 risk for skin breakdotherapy, auto immunicoccyxturn q (ever needed)" Medical record reviet Assessment dated May 29, 2012, was red and a protect applied daily. Medical record reviet assessment was cordinated record reviet assessment was cordinated was cordinated record reviet assessment record reviet assessment re	e with bed mobility, transfers Stage I pressure ulcer, was at t of pressure ulcers, and a levice was used on the bed levice was used on the levice of 17 or ekly skin antation in the medical levice of the Interim Care Plan revealed "Resident is at levin due to prednisone me diseaseStg (stage) 1 levice of the Admission Nursing May 25, 2012, revealed the	F	314	-		
	Assistant Director of conference room rev	ened" 2012, at 3:25 p.m., with the Nursing (ADON), in the ealed the resident was preducing mattress upon					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED MB NO. 0938-0391

		C MILDICAID OCKYICES				<u> OMB MÖ</u>	. 0938-0391
	T OF DEFICIENCIES OF GORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	ULTIPLE CONST	FRUCTION	(X3) DATE SURVEY COMPLETED	
,		445162	B. Wit	lG		07/1	6/2012
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDR	ESS, CITY, STATE, ZIP CODE	<u> </u>	
ASBURY	PLACE AT JOHNSO	N CITY		105 WEST)	MYTRLE AVENUE CITY, TN 37604		
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SS=D	admission to the face revealed the resider skin assessment are not receive a skin a 2012, until June 8, 2 Interview on July 12 physician, in the Addithe physician had vi 2012, when the president who the request of the frequently rejected or repositioning, and mound healing). Conthe resident's pressivas unavoidable du non-compliance. 483.25(d) NO CATHRESTORE BLADDE Based on the resident who enters indwelling catheter is resident's clinical concatheterization was who is incontinent of treatment and service infections and to resident's possible. This REQUIREMEN by: Based on medical rethe facility failed to for the facility failed to fail the fail the fac	cility. Continued interview int was to receive a weekly and confirmed the resident did essessment from May 29, 2012, a three day delay. If 2012, at 12:25 p.m., with the ministrator's office, revealed sited the resident on June 8, asure ulcer increased to Stage the nursing staff, the resident care, (turning and redications to assist with antinued interview revealed ure ulcer declined quickly and the to the resident's IETER, PREVENT UTI, IETER, int's comprehensive allity must ensure that a the facility without an sonot catheterized unless the indition demonstrates that increasing and a resident of bladder receives appropriate the set of prevent urinary tract for as much normal bladder. This not met as evidenced ecord review and interview follow physician's orders for	F3	1. 2. 15 3.	No Catheter, prever re bladder Foley catheter was con July 11, 2012 for Resident # 39. All other residents we foley catheters were to ensure proper fole Completed by 7/30/1	hanged with assessed by care. 2. elling d. The s re- t theter ley care. 8/10/12. we will its of lling roper ence to	
	care and services fo one (#39) of forty sa	r an indwelling catheter for			current policy. Audi	its will	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICARD SERVICES

T-472 P0023/0040 F-224

FORM APPROVED

STATEME	NT OF DEFICIENCIES	CAN PROMOTE COMPANY	T:			OMB NO	0. 0938-0391
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF	PROVIDER OR SUPPLIER	<u> </u>		STS	REET ADDRESS, CITY, STATE, ZIP CODE	<u> 07/</u>	16/2012
ASBUR	Y PLACE AT JOHNSO	N CITY		1	05 WEST MYTRLE AVENUE OHNSON CITY, TN 37604		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	T	۲,			,
PREFIX TAG	LEAGH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REPERENCED TO THE APPR DEFICIENCY)	ULDBE	(X5) COMPLETION DATE
F 315	The findings include	•	FS	315	be completed on 5 res per week for 4 weeks 10 residents per mont months.	then	
	May 21, 2012, with a Retention. Medical record revie May 2012, revealed catheter every mont Medical record revie admitted to the hospital documen catheter was change the hospital. Observation on July revealed the resident therapy room. Observation or processed the resident therapy room.	diagnosis including Urinary wo of physician's orders dated orders to change indwelling h. w revealed the resident was sital on May 18, 2012, and by on May 21, 2012. Review tation revealed the resident's ad on May 21, 2012 while in 11, 2012, at 9:55 a.m., at sitting in a wheelchair in the vation revealed a urinary sted to the wheelchair.			The results of the aud be reviewed at the Qu Assurance Committee (DON, Administrator, Facilities Director maintenance and housekeeping, MDS, Pharmacy, Social Services) Medical Director, AD Dining Services) mee monthly for three (3) and recommendations as appropriate.	vices, ON, ting months	
SS=D	the DON's office on confirmed the indwel changed since readn 483.25(f)(1) TX/SVC MENTAL/PSYCHOS Based on the compreresident, the facility nwho displays mental difficulty receives appservices to correct the	ocial difficulties chensive assessment of a nust ensure that a resident or psychosocial adjustment propriate treatment and	F 31	19	F319 NTX/SVC for Mental/Psychosocial difficulty. 1. Psychiatric services we obtained for Resident and # 106 on July 12, 2. All resident charts we reviewed to assure the orders for Psychiatric services were complete.	rere # 109 2012. re	

08~03-112 11:58 FROM-

DEPAR	IMENI OF HEALTH	I AND HUMAN SERVICES		T-472		840 F-224
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			FORM APPROVE OMB NO. 0938-039	
STATEMEN AND PLAN (T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUFFLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL	JLTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED	
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NAME OF I	ROVIDER OR SUPPLIER		'- -	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	16/2012
ASBURY	PLACE AT JOHNSO	N CITY	į	105 WEST MYTRLE AVENUE JOHNSON CITY, TN 37604		
(X4) ID PREFIX TAG	I (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID • PREFIX TAG	PROVIDER'S PLAN OF CORRECT	ULD BE	(X5) COMPLETION DATE
	by: Based on medical in the facility failed to on the facility failed to one timely for two (#109 residents reviewed. The findings include Resident #109 was 24, 2012, with diagnous Hypertension, and Signature Medical record revied dated May 25, 2012 (psychiatric) consult (Anti-Aizheimer's) of daily" Medical record revied July 12, 2012, revead (patient) is frequently packingbelongings homerecommendationamenda and aricepolicity are at likely sutherefore unlikely to	record review, and interview, obtain psychiatric services , #106) residents of forty d: admitted to the facility on May oses including Depression, renile Dementia. w of a physician's order , revealed "PsycheDementiaNamenda mg (milligrams)twice w of a Psychiatric Note dated led "behavioral findingspt	F3	Physician orders. Completed on 7/17/12. 3. All orders for Psychiatt evaluations will be monitored by Social Services for timely completion. 4. Social Services or design will conduct random at of Residents charts to a orders for Psychiatric evaluations have been completed per Physicia orders. Audits will be on 5 residents per week weeks, then 5 residents month for 3 months. The results of the audits be reviewed at the Qual Assurance Committee	gnee adits ssure done for 4 per	7/17/12

to 37.5mg q (every) am, would try to keep

Interview on July 11, 2012, at 3:15 p.m. in the conference room, with the Social Service

Director, confirmed psychiatric services had not seen the resident timely from May 25, 2012, (date

antihistamine use...to a minimum..."

of order) until July 12, 2012.

(DON, Administrator,

Pharmacy, Social Services, Medical Director, ADON,

Dining Services) meeting monthly for three (3) months

Facilities Director

maintenance and housekeeping, MDS, 48-42 TT:28 FROM-

T-472 P0025/0040 F-224 DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO: 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 445162 07/16/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ASBURY PLACE AT JOHNSON CITY **106 WEST MYTRLE AVENUE** JOHNSON CITY, TN 37604 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X5) COMPLETION DATE PREFIX TAG TAG DEFICIENCY) F 319 Continued From page 20 F 319 and recommendations made Resident #106 was admitted to the facility on May as appropriate. 14, 2012, with diagnoses including Mental Disorder, Osteoporosis, and Dementia. Medical record review of a physician's order F323 Free of Accident dated May 17, 2012, revealed "...psyche Hazards/Supervision/Devices consult-impulsive behavior, dementia..." 1. The bed pad alarm for Medical record review of a Psychiatric Note dated Resident # 90 was July 12, 2012, revealed "...behavioral findings...pt (patient) is frequently anxious and restless, with immediately reconnected poor sleep...recommendations...would d/c and checked to assure alarm (discontinue) celexa (Anti-Depressant) and was functioning ambien (sleep), and start remeron. appropriately. (Anti-depressant) 7.5mg q hs (bedtime)-this will hopefully also aid appetite...' The side rails were assessed Interview on July 11, 2012, at 2:45 p.m., in the for proper placement for conference room, with the Social Service Resident #72 and side rail Director, confirmed psychiatric services had not seen the resident timely from May 17, 2012, (date assessment was completed. of order) until July 12, 2012. F 323 483.25(h) FREE OF ACCIDENT F 323 The bed pad alarm for SS=D | HAZARDS/SUPERVISION/DEVICES Resident # 106 was immediately reconnected on The facility must ensure that the resident 7/12/12 and checked to environment remains as free of accident hazards as is possible; and each resident receives assure alarm was functioning adequate supervision and assistance devices to appropriately. The fall mats

prevent accidents.

This REQUIREMENT is not met as evidenced

Based on medical record review, observation.

and interview, the facility failed to ensure safety

for Resident #106 were appropriately replaced at bedside at the time of the interview on July 16, 2012.

2. All alarms and fall mats

were identified and checked

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICARD SERVICES

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F 323 Continued From page 21 devices were in place and functional for three (#90, #72, and #106) of forty residents reviewed. The findings included: Resident #80 was admitted to the facility on January 15, 2011, with diagnoses including Dementia with Behavior Disturbance, Congestive Heart Failure, Hypertension, and Atherosclerotic Cardiovascutar Disease. Medical record review of the Minimum Data Set dated March 22, 2012, revealed the resident was independent with transfers and ambulation, scored a 9 on the Brief Interview for Mental Status (BIMS) indicating the resident had moderately impaired cognitive skills, and had experienced a fall without injury since the prior assessment. Medical record review of the Minimum Data Set dated June 18, 2012, revealed the resident required supervision with transfers and walking in room, scored a fifteen on the Brief Interview for Mental Status, indicating the resident was independent with daily decision making, and had no falls since the prior assessment. Medical record review of the Fall Risk Assessment dated December 29, 2011, March 23, 2012, and June 18, 2012, revealed the resident resident was at high risk for falls. Medical record review of the Fall Risk Assessment dated December 29, 2011, March 23, 2012, and June 18, 2012, revealed the resident resident was at high risk for falls. Medical record review of the Fall Risk Assessment dated December 29, 2011, March 23, 2012, and June 18, 2012, revealed the resident was at high risk for falls. Medical record review of the Fall Risk Assessment dated December 29, 2011, March 23, 2012, and June 18, 2012, revealed the resident was at high risk for falls. Medical record review of the Fall Risk Assessment dated December 29, 2011, March 23, 2012, and June 18, 2012, revealed the resident was at high risk for falls. Medical propertical by 8/10/12. 4. The DON or designee has re-educated the nursing staff on proper use of alarms. To be completed by 8/10/12. 4. The DON or designee has re-educated the nursing staff on proper	CLIMIT	NO I OIL WILDIOARE	O MEDICAID SERVICES			<u> </u>	<u>. บรงจ-บงยา</u>
ASBURY PLACE AT JOHNSON CITY CAGID PREFIX FREGULATORY ORLSC DEPICIENCIES F 323 Continued From page 21 devices were in place and functional for three (#90, #72, and #106) of forty residents reviewed. The findings included: Resident #90 was admitted to the facility on January 15, 2011, with diagnoses including Dementia with Behavior Disturbance, Congestive Heart Failure, Hypertension, and Atheroscierotic Cardiovascular Disease. Medical record review of the Minimum Data Set dated March 22, 2012, revealed the resident was independent with transfers and arnbulation, accred a 9 on the Brief Interview for Mental Status (BIMS) indicating the resident had moderately impaired cognitive skills, and had experienced a fall without injury since the prior assessment. Medical record review of the Minimum Data Set dated June 18, 2012, revealed the resident was independent with daily decision making, and had no falls since the prior assessment. Medical record review of the Fall Risk Assessment dated December 29, 2011, March 23, 2012, and June 18, 2012, revealed the resident was at high risk for falls. Medical proord review of the Fall Risk Assessment dated December 29, 2011, March 23, 2012, and June 18, 2012, revealed the resident was at high risk for falls. Medical proord review of the Fall Risk Assessment dated December 29, 2011, March 23, 2012, and June 18, 2012, revealed the resident was at high risk for falls.	STATEMEN AND PLAN (T OF DEFICIENCIES OF CORRECTION		1	• •		
ASBURY PLACE AT JOHNSON CITY (X4)1D (X4)1D (X4)2D	•	•	445162	B. WIN	IG	07/1	6/2012
PROPERTY FLATERIST OF DEFICIENCIES FACE PROPERTY PLAN OF CORRECTION PRESENT PROPERTY PLAN OF CORRECTION PLAN OF CORRECTION PROPERTY PLAN OF CORRECTION PROPERTY PLAN OF CORRECTION PLAN OF CORRECTION PROPERTY PLAN OF CROSS PERCECEDED OF			N CITY		105 WEST MYTRLE AVENUE		
devices were in place and functional for three (#90, #72, and #106) of forty residents reviewed. The findings included: Resident #90 was admitted to the facility on January 15, 2011, with diagnoses including Dementia with Behavior Disturbance, Congestive Heart Failure, Hypertension, and Atherosclerotic Cardiovascular Disease. Medical record review of the Minimum Data Set dated March 22, 2012, revealed the resident was independent with transfers and ambulation, accored a 9 on the Brief Interview for Mental Status (BIMS) indicating the resident had moderately impaired cognitive skills, and had experienced a fall without injury since the prior assessment. Medical record review of the Minimum Data Set dated June 18, 2012, revealed the resident was independent with transfers and walking in room, scored a fifteen on the Brief Interview for Mental Status, indicating the resident was independent with daily decision making, and had no falls since the prior assessment. Medical record review of the Fall Risk Assessment dated December 29, 2011, March 23, 2012, and June 18, 2012, revealed the resident was at high risk for falls. Medical precord review of the Care Plan dated. The DON or designee has re-educated the nursing staff on proper use of alarms. To be completed by 8/10/12. 4. The DON or designee has re-educated the nursing staff on proper use of alarms. To be completed by 8/10/12. 4. The DON or designee has re-educated the nursing staff on proper use of alarms. To be completed by 8/10/12. 4. The DON or designee will conduct random audits of resident alarms and fall mats for proper placement and functionality. To be completed by 8/10/12. 4. The DON or designee will conduct random audits of resident alarms and fall mats for proper placement and functionality. To be completed by 8/10/12. 4. The DON or designee will conduct random audits of resident alarms and fall mats for proper placement and functionality. To be completed by 8/10/12. 4. The DON or designee will conduct random audits of resident send alarm	PREFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREFD	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOULD BE	(X5) COMPLETION DATE
May 24, 2012, revealed "is at risk for fall d/t (due to) unwillingness to wait for assistance while transferringassistto wear non-slick footwear that fitsattempt to engagein ADLs (activities of		devices were in pla (#90, #72, and #10) The findings include Resident #90 was a January 15, 2011, v Dementia with Beha Heart Failure, Hype Cardiovascular Disc Medical record revie dated March 22, 20 independent with tra scored a 9 on the B Status (BIMS) indica moderately impaired experienced a fall w assessment. Medical record revie dated June 18, 2012 required supervision room, scored a fifter Mental Status, indic independent with da no falls since the pri Medical record revie Assessment dated I 23, 2012, and June resident was at high Medical record revie May 24, 2012, reveal (due to) unwillingnes transferringassist	ce and functional for three 3) of forty residents reviewed. ad: admitted to the facility on with diagnoses including avior Disturbance, Congestive rtension, and Atherosclerotic ease. ew of the Minimum Data Set 12, revealed the resident was ansfers and ambulation, rief Interview for Mental ating the resident had a cognitive skills, and had without injury since the prior ew of the Minimum Data Set 2, revealed the resident was a with transfers and walking in en on the Brief Interview for ating the resident was ally decision making, and had or assessment. ew of the Fall Risk December 29, 2011, March 18, 2012, revealed the risk for falls. ew of the Care Plan dated alled "is at risk for fall d/t as to wait for assistance whileto wear non-slick footwear	F 3:	functionality. To be completed by 8/3/12 3. The DON or design re-educated the nurs on proper use of ala be completed by 8/14 4. The DON or design conduct random and resident alarms and for proper placement functionality. Audit completed on 10 resper week for 4 week 10 residents per more months. The results of the and be reviewed at the CAssurance Committ (DON, Administrate Facilities Director maintenance and housekeeping, MDS Pharmacy, Social S Medical Director, A Dining Services) monthly for three (3 and recommendation)	ee has sing staff rms. To 10/12. ee will dits of fall mats at and ts will be sidents as, then anth for 3 adits will Quality tee or, s, ervices, aDON, eeting s) months	8/10/12

08-03-'12 11:59 FROM-

T-472 P0027/0040 F-224 DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING B. WING 445162

	445162		· · · · · · · · · · · · · · · · · · ·	07/1	6/2012
	PROVIDER OR SUPPLIER Y PLACE AT JOHNSON CITY	1	REET ADDRESS, CITY, STATE, ZIP CODE 05 WEST MYTRLE AVENUE		WAV IL
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX YAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOTH CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD 8E	(X5) COMPLETION DATE
	daily living) that improve strength, balance, and postureInstruct on safety measures to reduce the risk of falls (posture, changing positions, use of handralls)chair pad alarm, keep areas free of obstructions to reduce the risk of falls or injuryKeep nurse call light within easy reach. Instructto use call bell or call out for assistanceKeep personal items within easy reach, bed to be in lowest position with wheels lockedauto-lock brakes to wheelchairbedpad alarm" Medical record review of the nursing notes dated April 24, 2012, at 5:15 p.m., revealed "Resident found on bathroom floor with W/C (wheelchair) brakes unlocked. Resident c/o severe generalized back painFNP (Family Nurse Practitioner) notified and Lortab 5/500 (pain medication) now ordered to control pain also total spine x-ray ordered to determine that no injury was obtainedIntervention placed for q (every) 2 hr (hour) toileting schedule for resident to ensure safety upon BR (bathroom) visits" Medical record review of an x-ray report of the portable spine dated April 24, 2012, revealed there were no acute fractures or subluxations identified. Review of the facility's Fall Investigation revealed when the fall occurred on April 24, 2012, the resident stated "i slid out of the chair" and the w/c (wheelchair) brakes were unlocked. Medical record review of a Therapy Screen dated April 25, 2012, revealed the resident had experienced a fall on April 24, 2012. Continued review of the Therapy Screen revealed	F 323			

08-03-'12 11:59 FROM-

T-472 P0028/0040 F-224

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED

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	f of deficiencies of correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 .	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	· · · ·	445162	B. WI	NG_		07/1	6/2012	
	ROVIDER OR SUPPLIER PLACE AT JOHNSO	N CITY		1	REET ADDRESS, CITY, STATE, ZIP CODE 105 WEST MYTRLE AVENUE 10HNSON CITY, TN 37604			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIES OF THE PROPRIES OF T	ULD BE	(XS) COMPLETION DATE	
	"Resident observe injury notedbrake Multidisciplinary Me Interview on July 11 Physical Therapy A room, revealed at the April 24, 2012, the invineelchair were in subserved on July 11 maintenace worker, confirmed the braker esident's wheelchair were repaired a 24, 2012. Observation on July Licensed Practical I resident lying on the and interview revea alarm was lying on the and interview with LPN and interview with LPN and interview with LPN and the servation, confirm functional. Resident #72 was a 16, 2009, with diagrosteoporosis. Medical record review Assessment dated in the resident was at Medical record review (MDS) dated May 16	ad in BR (bathroom) floor. No repair as per discussion in setting" 1, 2012, at 12:50 p.m., with the seistant, in the conference time of the resident's fall on brakes on the resident's need of repair. 1, 2012, at 1:30 p.m., with the in the conference room, as on the right side of the air, were loose and not locking after the resident's fall on April of the cord to the bedpad the bed. Continued observation led the cord to the bedpad the floor beside the bed, with led to the resident's bed. 41, at the time of the need the bedpad alarm was not dimitted to the facility on April loses including Dementia and lew of the Fall Risk February 2, 2012, revealed high risk for falls.	F	323				
1	scored a one on the	Brief Interview for Mental				i		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/					OMB NO. 0938-039		
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	FLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
	·	445162	B. WING_				
	PROVIDER OR SUPPLIER PLACE AT JOHNSO	N CITY	10	REET ADDRESS, CITY, STATE, ZIP CODE 05 WEST MYTRLE AVENUE OHNSON CITY, TN 37604	<u></u>	16/2012	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULDBE	(XS) COMPLETION DATE	
	Status, indicating the impaired cognitive adependent for bed a not fallen since the Medical record revieway 24, 2012, reveal (side rails) (up) X (till while in bed" Medical record revieway at 7: observed by CNA (as siding to floor from mattsCNA exited the cart & (and) when recocurAssessed by Intervention in place bedrail when exiting Review of the facility Jurie 18, 2012, revealing the cart & (and) when exiting Review of the facility Jurie 18, 2012, revealing the cart & (and) when exiting the cart & (and) when exiting the conference of the facility Jurie 18, 2012, revealing the cart & (and) when exiting the conference of the facility Juries related to the linterview on July 12, Assistant Director of conference room, relinvestigated the fall the cart is a second of the fall the conference of the fall the cart of the fall the cart is a second of the cart i	e resident had severely skills, did not walk, was totally mobility and transfers, and had prior assessment. Bew of the Care Plan dated aled "History of fallsSR mes) 2mat @ (at) bedside Bew of the nursing notes dated 30 p.m., revealed "Resident Certified Nursing Assistant) low bed to bedside room to place tray on meal aturned to room saw this rourse & lifted safely into bed, of educating CNA to replace room" By's fall investigation dated aled the resident had no a fall on June 18, 2012. 2012, at 8:30 a.m., with the Nursing (ADON), in the vealed the ADON had the resident experienced on confirmed the CNA had not confirmed the CNA had not	F 323				
	14, 2012, with diagno	admitted to the facility on May oses including Mental als, Vertebral Fracture, cident, and Dementia.	-		;		

Medical record review of the fall risk assessment

08-03-'12 12:00 FROM-

2 12:00 FROM-

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

T-472 P0030/0040 F-224 FORM APPROVED OMB NO 0938-0391

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		445162	445162 B. WING			07/16/2012		
ASBURY PLACE AT JOHNSON CITY				16	REET ADDRESS, CITY, STATE, ZIP CODE 06 WEST MYTRLE AVENUE OHNSON CITY, TN 37604			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORF PREFIX (EACH CORRECTIVE ACTION S TAG CROSS-REFERENCED TO THE AI DEFICIENCY)			OULD BE	(X5) COMPLETION DATE	
F 323	dated May 15, 201. the resident was all Medical record revidated May 14, 201; alarmfall risk" Medical record revion June 7, 2012, revenue 3, 2012, revenue 9, 2012, revenue 9, 2012, revenue sitting on the flowas down and bed beside bed on the (approximately) 3/4. Medical record revidate 10, 2012, revenuesing staff to be sitted on the proximately) 3/4. Medical record revidates 10, 2012, revenuesing staff to be sitted on the proximately of the side onto floor. Observation on July 12 conference on July 12 conference room, was all 1/4 side onto floor.	2, and June 25, 2012, revealed high risk for falls. iew of a physician's order 2, revealed "Bed pad ew of the care plan reviewed evealed "bed pad atarmmat n bed" iew of the Nursing Note dated aled "Res. (resident) noted to or besidebed. SR (siderail) atarm was in the drawer except (right) sideabrasion approx. (inches) long onmid-back" iew of a Therapy Screen dated ealed "Resident observed by sliding off edge of bed onto "" y 12, 2012, at 7:40 a.m., with Nurse (LPN) #2 revealed the floor in the mid bed position. It in revealed the bed pressure connected to the alarm box it on revealed the alarm box it on revealed the alarm box it on revealed the alarm box if the closet. 1, 2012, at 9:45 a.m., in the rith the Assistant Director of the safety device was not in I on June 9, 2012.	F;	323				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		445162	B. WIN	····		07/16/2012		
	NAME OF PROVIDER OR SUPPLIER ASBURY PLACE AT JOHNSON CITY			STREET ADDRESS, CITY, STATE, ZIP CODE 105 WEST MYTRLE AVENUE JOHNSON CITY, TN 37604				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			X (EA(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 325 SS≕G	Observation and int Nursing on June 16 the resident lying in up in the mid bed po- mats were not in pla 483.25(i) MAINTAIN UNLESS UNAVOID Based on a resident assessment, the fac- resident - (1) Maintains accept status, such as body unless the resident's demonstrates that ti	erview with the Director of 2012, at 1:30 p.m, revealed a low bed with 1/4 sideralis sition, and confirmed the fall ice. I NUTRITION STATUS ABLE 's comprehensive illity must ensure that a table parameters of nutritional weight and protein levels.	F3	<u>F325</u> <u>Status</u> 1.	Maintain Nutritions on unless unavoidable Order for mighty shat Resident # 106 was a by Dietary department placed on Resident's tray on 7/12/12. Registered Dietician notified of weight lost Resident # 106 on 7/12/12. Resident # 106 was a pon Hospice services of 7/16/12.	was ss for 16/12.		
	by: Based on medical refacility policy, observed facility failed to preve for one (#106) reside reviewed. The facilities failure refacilities failure refac	esulted in harm to resident		2.	Weight management was reviewed. Mont Weekly weights for a Residents were revie 7/17/12 to assure apprinterventions were infor weight loss per per con 7/17/12, all reside Physicians orders we reviewed to ensure the proper supplements have been provided.	thly / all wed on propriate place olicy. ents ere	7/17/12	

T-472 P0032/0040 F-224

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MICUICARE & MEDICAID SERVICES				<u> </u>	OMP 140' 0930-0381		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A, BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		445162	B. WII	- EN		07/16/2012	
NAME OF P	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE		
ASBURY PLACE AT JOHNSON CITY					05 WEST MYTRLE AVENUE OHNSON CITY, TN 37604		:
(X4) ID PREFIX TAG	(EACH DEFICIENCY	(TEMENT OF DEFICIENCIES I MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	COMPLETION DATE
F 325	Accident, and Dem Medical record revi Assessment dated (weight) 115 (pound 105 (pounds)Diet Medical record revi June 4, 2012, revea the hospital, (6-2-1) colonoscopyappe (above)IBWme wt 115 (pounds)" Review of the weig weighed 111 pound Review of the weig weighed 105 pound loss in one month). Medical record revi dated July 5, 2012, with meals" Review of the July, revealed the might administered on Ju 2012, three times a Medical record revi dated July 9, 2012, (change) to mecha Medical record revi dated July 9, 2012, (change) to mecha	ew of the Nutritional May 14, 2012, revealed, "wt. ds) IBW (Ideal Body Weight) c Order: Regular" ew of the dietary note dated aled "Resident returned from 2)had a sitte is fair10 (pounds) chanical soft dietlow residue, the record revealed the resident ds on June 6, 2012. Intercord revealed the resident ds on July 3, 2012, (5% weight ew of a physician's order revealed, "Mighty shakes 2012, Medication Record y shakes were initialed as dy 6, 2012, through July 11, a day. iew of a physician's order revealed "diet texture nical soft solids/thin liquids" iew of a dietary note dated July "weight on 6/7/12111.0 sident) has had wt (weight) sincereturned from the	F	325	3. The DON or designed re-educated the nursing on Weight Management policies and procedure be completed by 8/10/2. 4. The DON or designed conduct random auditives ident's charts that he experienced weight located the ensure that Dietician here appropriately not Audits will be comple 5 residents per week feweeks, then 5 resident month for 3 months. The DON or designed conduct random audits Residents with dietary supplements to ensure delivery per Physician Audits will be complet 10 residents per week weeks, then 10 resident month for 3 months. The results of the audit be reviewed at the Quantum Assurance Committee (DON, Administrator,	g staff ent es. To /12. will s of nave ss to nas diffied. ted on or 4 s per will for order. ted on for 4 ats per	8/10/12
	loss of 10 (pounds)	sincereturned from the receive super cereal for			(DON, Administrator,		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED OMB NO. 0938-0391

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		445162	B. Wing			07/16/2012		
	ROVIDER OR SUPPLIER PLACE AT JOHNSO	N CITY		1	REET ADDRESS, CITY, STATÉ, ZIP CODE 06 WEST MYTRLE AVENUE IOHNSON CITY, TN 37604			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF GORREC (EACH CORRECTIVE ACTION SHO GROSS-REFERENGED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
·	breakfast (and) sha extra cals (calories; precaution for furth. Medical record revidated July 13, 2012 (appetite stimulant) mouth) q (every) da (at) breakfast (and). Review of the facilit revealed, "all reschange will be asseresidents will be proincreased calorie are supplements or plantherapy Program Observation on July revealed the breakfresident with 2% mit toast, and egg. Furth mighty shake on the Confirmed no mit tray or on the meal tray or on the m	ake tid (three times a day) for (and) pro. (protein) as a er wt. loss" ew of a physician's order large and milligrams) po (by and mil		325	Facilities Director maintenance and housekeeping, MDS Pharmacy, Social Se Medical Director, Al Dining Services) me monthly for three (3) and recommendation as appropriate.	rvices, DON, cting) months		

08-03-12 12:00 FROM-DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

T-472 P0034/0040 F-224

FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		445162	B. WIN	G	07/1	6/2012	
NAME OF PROVIDER OR SUPPLIER ASBURY PLACE AT JOHNSON CITY				STREET ADDRESS, CITY, STATE, ZIP O 105 WEST MYTRLE AVENUE JOHNSON CITY, TN 37604	CODE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(D PREFI) TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 325	conference room, we confirmed the dietal received the order of the tree of the order of the tree of th	icket. 2, 2012, at 9:00 a.m. in the with the Food Service Director ry department had not for the mighty shakes. 2, 2012, at 1:40 p.m., in the with LPN #3, confirmed the nitialed as administered on 11, 2012, at 8:00 a.m., and ar LPN #3 confirmed did not a shake on the resident's tray. It record revealed the resident on July 13, 2012. (9 pound is, 2012, at 2:00 p.m., in the with the Food Service Director, atered Dietician had not	F3	25			
	483.55(b) ROUTINI SERVICES IN NFS	}	F 4	12			
	The nursing facility	must provide or obtain from				l	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED OMB NO. 0938-0391

IPLE CONSTRUCTION (X3) DATE SURVEY

OT4754154	TATTER DE BROADERS		····				OWD NO. 0830-0391		
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
'	445162		B. WI	NG_			07/16/2012		
NAME OF PROVIDER OR SUPPLIER ASBURY PLACE AT JOHNSON CITY			STREET ADDRESS, CITY, STATE, ZIP CODE 106 WEST MYTRLE AVENUE JOHNSON CITY, TN 37604						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION)		,	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(%) COMPLETION DATE	
F 412	an outside resource §483.75(h) of this p covered under the § dental services to m resident; must, if ne making appointmen transportation to an	e, in accordance with art, routine (to the extent State plan); and emergency neet the needs of each cessary, assist the resident in its; and by arranging for d from the dentist's office; and residents with lost or	F	412			,		
	by: Based on medical rand interview, the fadental services for dreviewed. The findings include Resident #80 was a January 9, 2010, with Hypertension, Dyspl Coronary Artery Disc Pulmonary Disease, Dementia. Medical record review (MDS) dated Novem dated May 2, 2012, included May 2, 201	dmitted to the facility on the diagnoses including hagia, Fractured Hip, ease, Chronic Obstructive Atrial Fibrillation, and ew of the Minimum Data Set aber 20, 2011, and the MDS revealed the resident had eavity or broken natural ew of the Care Plan dated February 16, 2012, and May 'has obvious or likely cavity ethschedule dental			1. 2.	Resident #80 will have dental evaluation comby 8/10/12. Resident has been evaluated for pain and no pain or willow noted at this time. As of 7/23/12 all Care for residents were audiensure no dental examomitted from resident of care. The DON or designed serviced the Interdisc Team on communicat Social Services when	re hpleted #80 or tooth reight Plans lited to hs were 's plan has in iplinary tion to	7/23/12	

08-03-'12 12:01 FROM-P0036/0040 F-224 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION COMPLETED A. BUILDING B. WING 445162 07/16/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, SYATE, ZIP CODE ASBURY PLACE AT JOHNSON CITY 105 WEST MYTRLE AVENUE JOHNSON CITY, TN 37604 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION ID PREFIX (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY F 412 Continued From page 31 F 412 indicated..." dental services are appropriate. To be Medical record review revealed no documentation 8/10/12 completed by 8/10/12. the resident had received a dental evaluation. 4. The DON or designee will Observation and interview on July 12, 2012, at 12:10 p.m., revealed the resident seated in a conduct random care plan wheelchair, in the resident's room, and the audits to ensure need for resident stated had several broken teeth. outside dental services are appropriately provided. Interview on July 11, 2012, at 4:45 p.m., with the Social Worker, in the conference room, Audits will be completed on confirmed the resident had not had a dental 5 residents per week for 4 evaluation since admission to the facility. weeks, then 5 residents per month for 3 months. The results of the audits will be reviewed at the Quality Assurance Committee (DON, Administrator, Facilities Director maintenance and housekeeping, MDS, Pharmacy, Social Services, Medical Director, ADON, Dining Services) meeting

monthly for three (3) months and recommendations made

as appropriate.